THE CARLAT REPORT
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CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

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IN THIS ISSUE

Focus of the Month:
Forensic Topics in Addiction

Learning Objectives

After reading these articles, you should be able to:

1. Understand how drug courts function and how best to interface with them as a mental health provider.
2. Implement strategies for helping patients with substance use disorders navigate the legal system.
3. Identify the potential legal impact of positive urine drug screens on patients.
4. Summarize some of the findings in the literature regarding addiction treatment.

A Clinician's Guide to Drug Courts

Stephen Wemakor, MD, Department of Psychiatry, Yale University, New Haven, CT; Noah Capurso, MD, MHS, Assistant Professor of Psychiatry, Yale University, & Editor-in-Chief, The Carlat Addiction Treatment Report.

Drs. Wemakor and Capurso have no financial relationships with companies related to this material.

Many of your patients with substance use disorders (SUDs) will encounter the legal system. People with SUDs face greatly increased risk of arrest, leading many into repeated legal challenges ending with jail or prison. Yet, most are not violent career criminals, but rather people with low-level offenses whose actions were influenced by addiction.

Drug courts were developed to divert such people away from incarceration and toward addiction treatment. Although data regarding their efficacy are mixed, their numbers have grown substantially over the past three decades (Brown RT, *Transl*

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Highlights From This Issue

Feature article
Many patients with substance use disorders encounter the legal system through drug courts, which prioritize treatment over punishment and may also seek collaboration with treaters.

Feature Q&A
Providers working with pregnant patients who have substance use disorders must notify Child Protective Services as part of their legal obligations.

Q&A on page 6
The period immediately following release from jail or prison is associated with high rates of drug overdose, presenting a critical opportunity for engaging patients in treatment.

Article on page 8
Urine drug screening results can have significant consequences for patients involved in the legal system.

Q&A With the Expert

Pregnancy, Addiction, and the Law

Elisabeth Johnson, PhD, FNP-BC, CARN-AP, LCAS

Division Director, UNC Horizons; Clinical Assistant Professor, UNC-Chapel Hill, Carrboro, NC.

Dr. Johnson has no financial relationships with companies related to this material.

CATR: How big of a problem is addiction in pregnancy?
Dr. Johnson: A 2020 Substance Abuse and Mental Health Services Administration (SAMHSA) survey showed that about one in 10 pregnant people reported using cannabis, nicotine, alcohol, stimulants, or illicit opioids within the previous month (www.tinyurl.com/yc6x4vcp). The overall pattern mimicked that of the general population, though with an overall lower prevalence, with cannabis and nicotine being the most common, followed by alcohol and other illicit substances.

CATR: Many pregnant patients who use substances worry about Child Protective Services (CPS) getting involved. How does CPS get alerted in the first place?
Dr. Johnson: To start, it's useful to understand the Child Abuse Prevention and Treatment Act (CAPTA). First passed in the 1970s, CAPTA

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Expert Interview – Pregnancy, Addiction, and the Law

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was meant to protect minors from abuse, which it defines broadly. It includes physical, emotional, and sexual abuse; exploitation; and anything that puts a child at "imminent risk of serious harm." The CAPTA Family Care Plan is a later addition focused on substance use. It requires CPS to be notified of all babies prenatally exposed to alcohol or other drugs.

CATR: And how is that reported?

Dr. Johnson: Well, it's not necessarily a report. The law requires that CPS get a "notification," which is simply informing them about the results of a toxicology screen. The term "report" is reserved for when you have more specific reasons to be concerned—the child is not safe, intentional harm, that sort of thing.

CATR: What are the mechanics of filing a notification? Are providers legally obligated to file the notifications themselves?

Dr. Johnson: As with so many legal questions, the answer is "it depends." CAPTA is federal legislation, but each state and county will have its own interpretation. The good news is that hospitals tend to have a set protocol. While the protocols might differ in their fine details, the broad strokes are similar across clinical settings.

CATR: Could you explain the protocol that your health care system follows, just to provide an illustrative example?

Dr. Johnson: In our hospital, policy requires a urine drug screen (UDS) on babies born to mothers with a history of a substance use disorder (SUD). If we detect anything unexpected, legally we have to notify CPS. We let the parents know about the notification. Most states have an online portal or a phone number to call.

CATR: And then what happens?

Dr. Johnson: Again, it depends. If the baby tests positive for a substance such as methamphetamine, cocaine, or opioids, CPS will usually do an investigation that includes a home visit and an interview with the family. The case usually stays open for 30–45 days. If CPS determines that the newborn has what they need and the environment is safe, the case will be closed.

CATR: What are the possible outcomes of these investigations?

Dr. Johnson: Resources might be recommended to the family, or CPS might continue to follow the case for a time. Parents can be connected to SUD treatment. Things can get more complicated when there are multiple children in the house or if there's been prior CPS involvement. But regardless of the outcome, it's important to acknowledge that these investigations can be intrusive and very stressful for families.

CATR: Can the baby be separated from the parents by CPS?

Dr. Johnson: Yes. In my hospital system, it is not common for CPS to prevent the baby going home with the family. When that does happen, it is almost always because there are other serious concerns—maybe prior CPS involvement, a history of domestic violence, or a history of child abuse. It's possible that a baby gets removed from the house because of that investigation we were discussing. If CPS determines that the home environment is unsafe, they have the authority to remove the child. This is usually not done solely based on a positive UDS, but because of other issues.

CATR: We've heard horror stories of babies getting taken away because a parent is on a medication for opioid use disorder (www.tinyurl.com/87f7zx6k). I imagine these types of stories might make patients hesitant to seek treatment.

Dr. Johnson: Yes, we've all read about these cases. Unfortunately, the multiple layers of legal interpretations can lead to some pretty extreme, and terrible, outliers. The risk of a bad outcome because of untreated opioid use disorder vastly outweighs the very small risk of something like this happening. In fact, opioid overdoses are the leading cause of death in the perinatal period, more than hemorrhage or obstetrical complications (Frankeberger J et al, *Matern Child Health J* 2023;27(7):1140–1155).

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Expert Interview — Pregnancy, Addiction, and the Law

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CATR: And what can our role be, as clinicians?

Dr. Johnson: Health care providers need to educate patients about the importance of SUD treatment and the risks associated with forgoing it. Almost all patients have the same priority: having a healthy and happy baby. Getting proper substance use treatment during pregnancy is the best way to make that happen. We've all heard the statement "buprenorphine or methadone is substituting one drug for another; it's not really being clean." We need to tackle this misconception head on. Explain that there is a big difference between getting an opioid agonist or partial agonist from a prescriber versus buying a possibly contaminated drug from an illicit source.

CATR: How do you go about working with these patients in the clinic?

Dr. Johnson: Many are scared, worried, ambivalent—all the emotions that anyone starting their recovery journey might feel, but magnified. I begin by acknowledging these feelings and their legitimacy. Patients are feeling guilt about exposing their future child to substances; they may feel shame or embarrassment about their situation. I start by praising them: "This is a hard journey. We're here to give you the support you need. How can we help?" I've found that framing the situation this way from the outset sets the stage for more effective work in the future.

CATR: And how do you respond when patients fear being separated from their baby?

Dr. Johnson: Again, I start by acknowledging whatever emotional reaction they're feeling. I return to the theme of treatment being the best way to have a healthy baby. But I also find that we can take a practical approach. I say to them "What can we do to make the best of this tough situation and demonstrate to CPS that you'll be a good parent?" The things that give CPS confidence in a patient's ability to provide a good home for a child are the same things that we recommend as health care providers. Despite those few outlier horror stories, CPS generally looks more favorably on buprenorphine than illicit opioids. I also stress the importance of good prenatal care—keeping regular obstetrical appointments, receiving other medical treatment, taking care of mental health issues.

"If a pregnant patient is worried about Child Protective Services (CPS) taking their child, I acknowledge their emotional reaction. Then I say 'What can we do to make the best of this tough situation and demonstrate to CPS that you'll be a good parent?' What gives CPS confidence in a patient's ability to provide a good home for a child are the same things healthcare providers recommend."

Elisabeth Johnson, PhD, FNP-BC, CARN-AP, LCAS

CATR: Any other tips for talking to patients about CPS?

Dr. Johnson: Establishing trust is essential. We usually know when we're going to have to notify CPS. Tell your patient ahead of time; let them know what to expect. CPS is not involved when the patient is pregnant but will be as soon as the notification is made. It shouldn't seem like going behind your patient's back. I sometimes say "Let's make this call together." It can be a tough conversation, but addressing it preemptively is preferable to being blindsided right after delivery.

CATR: We've talked a lot about the importance of good SUD treatment during pregnancy. What does that look like?

Dr. Johnson: It lies along a continuum. Some patients have been stable in recovery for years, so for them, keeping treatment in place is the way to go. It is sufficient for some to receive regular outpatient treatment, perhaps weekly, for the duration of the pregnancy. Others are actively using and struggling to stop. For them, we consider perinatal residential treatment. These are specially designed programs that deliver addiction care to pregnant people or those who have just given birth.

CATR: Those facilities sound great, but they also sound expensive.

Dr. Johnson: Accessibility is a big issue. But that doesn't mean elements of these programs can't be implemented in other settings. I'm a bit spoiled with my clinic's integrated prenatal and behavioral health care. Here, patients come to their OB appointment, see a therapist, a case manager, maybe a psychiatrist or a peer support. We educate patients about 12-step programs and other resources such as SMART Recovery. Even in settings where these services aren't integrated, it's key to focus on outreach, collaboration with other providers, and communication across disciplines. When possible, make referrals to local services. One silver lining of COVID is that many resources went online and have stayed online, and that helps accessibility.

CATR: What resources would you recommend for providers caring for pregnant patients with addiction?

Dr. Johnson: Familiarize yourself with local laws and regulations. There are online resources that lay out the differences (www.tinyurl.com/5n72e545). If you are unsure, call your hospital's legal department. It's also helpful to know community resources so you can refer your patients if needed. I would also encourage reviewing the Academy of Perinatal Harm Reduction's online toolkit (www.tinyurl.com/wa4kracf). And finally, I recommend SAMHSA's resources on caring for pregnant people with SUDs (www.tinyurl.com/ye4cmykn).

CATR: Thank you for your time, Dr. Johnson.

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A Clinician's Guide to Drug Courts

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Res 2010;155(6):263–274; www.ojp.gov/feature/drug-courts/overview).

As a provider, you will likely encounter patients involved with drug courts, and you may be asked for treatment recommendations, documentation of adherence, or lab results. Understanding how these courts function will ensure you can work with them effectively and in your patients' best interests.

What are drug courts?

Drug courts are designed for defendants facing nonviolent drug charges such as possession or petty theft. Their setup doesn't differ substantially

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Sample Drug Court Letter for a Patient With OUD

[Date]
[Your name and contact information]

Re: *[Patient Name]*

To Whom It May Concern:

This letter is regarding *[patient name and date of birth]*, who has been under my care at *[clinic name]* since *[date]*. I have been treating them for opioid use disorder [list other conditions you are treating] with the medication *[buprenorphine, methadone, or IM naltrexone]*. This medication is sometimes known as Medication for Opioid Use Disorder (MOUD) or Medication Assisted Treatment (MAT).

Their treatment plan also includes: *[list all treatment components including appointment frequency, psychotherapy, group therapy, and other medications]*. Their progress will be measured by attendance at medical and therapy appointments, as well as their ability to abstain from using substances as determined by urine drug screening [specify interval].

I strongly recommend the continued use of *[buprenorphine, methadone, or IM naltrexone]*. Research clearly shows that this FDA-approved medication, and others like it, are essential components to the effective treatment of opioid use disorder. Despite misconceptions, these medications do not "substitute one addiction for another". Stopping the medication would put them at high risk of returning to opioid use and potential overdose.

In terms of progress, *[patient name]* has attended medical appointments with me on *[list dates]* and therapy appointments on *[list dates]*. Results of urine drug screening at these appointments have been *[list drug screen results here]*.

In summary, my medical recommendation is that *[patient name]* continue taking *[medication]*, attend regular appointments and therapy sessions *[specify frequency]*, and have their progress monitored by urine drug screening. Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[Your name and full credentials]

Use company or clinic letterhead

MAT is still a commonly used acronym

The goal is to outline a comprehensive treatment plan, beyond just medications

Advocate for MOUD, which some courts may discourage. Consider addressing common misconceptions at the outset.

If this is not your initial letter to the court, provide an update with your patient's progress. Include other relevant clinical details if indicated.

Provide "wet" ink signature

Adapted from: Legal Action Center (www.tinyurl.com/ym2yfh6r)

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from traditional criminal courts. They consist of a judge, attorneys on both sides, and court personnel. The difference is that drug court judges explicitly consider the role of addiction in the alleged crime and favor sentences of mandatory drug treatment and continued sobriety instead of incarceration (DeVall K et al. *Painting the Current Picture: A National Report on Treatment Courts in the United States.* National Drug Court Resource Center. May 22, 2023). Currently, there are over 4,000 drug courts in the US. Proponents believe they are a cost-effective means of getting people into treatment and reducing the likelihood of rearrest (www.ndcrc.org/what-are-drug-courts/).

How do drug courts work?

People who test positive for drugs at arrest or have a documented history of SUD may be referred to a drug court by their attorney, a judge, law enforcement, or a prosecutor. Those accused of severe crimes, such as felonies, or those with a history of violent offenses or drug trafficking are usually directed to the standard criminal court system.

One key aspect that sets drug courts apart is the continuity of judicial interaction beyond the first hearing. Participants engage in periodic check-ins, often for six to 12 months. These sessions evaluate the participant's compliance with court-mandated requirements, which usually include adhering to SUD treatment, maintaining sobriety, avoiding further arrest, and possibly even securing stable housing and employment.

Advantages

Drug courts offer participants the opportunity to avoid incarceration, focusing on recovery over punishment. Ongoing hearings allow for the tailoring of program requirements to suit individual progress. Doing well can lead to decreased supervision and extended intervals between court appearances. Upon successful completion of a recovery program, a participant's charges may be expunged.

Disadvantages

Critics argue that drug courts can be seen as coercive by dictating treatment, can create burdensome time commitments, and are subject to racial disparities (Nicosia N et al, *Am J Public Health* 2013;103(6):e77–e84). Insisting on abstinence as a marker of success does not acknowledge the natural course of SUDs, which for many includes a return to use.

Noncompliance with court mandates can lead to imprisonment or getting funneled back into the traditional criminal court system. Furthermore, many drug courts require participants to plead guilty to enter the program, known as a "post-plea" arrangement. This means that if participants falter in fulfilling the court's conditions, they risk sentencing based on their earlier guilty plea.

In some instances, drug courts can dictate which treatments patients receive. Restrictions may include prohibitions on out-of-state residential programs or certain medications, particularly medications for opioid use disorder (MOUD). In such cases, discuss with your patients the risks of forgoing treatment, be sure they understand the implications of complying with the drug court's mandates, and allow them to decide their preferred course of action. If a local drug court is going against your medical recommendation, consider reaching out and providing education.

Your role as a provider

Communicating with courts

You may be asked to:

- Outline initial treatment plans, including medication or therapy recommendations
- Update the court on your patient's attendance, medication adherence, and urine drug screens as the case progresses

See page 4 for a template of an initial letter to a drug court for a patient with opioid use disorder, including language that advocates for MOUD treatment.

Communicating with patients

Maintain transparency regarding your involvement in legal matters. Your patient should know that you are an advocate for their well-being rather than an agent of the court. Should the court request documentation, obtain your patient's consent, preferably written, before sharing any information. Depending on the setting, a release that complies with 42 *CFR* Part 2 may be required (www.tinyurl.com/4tvnv8hr). Review the letter with the patient, ensuring they are comfortable with the disclosure of their diagnosis, treatment plan, and progress.

In some instances, you may be unsure how to proceed. If a patient has been only partially adherent to their treatment program, would it be best to provide a letter outlining that partial adherence or to not provide a letter at all? What if a patient wants you to include some pieces of information but omit others? Patients must understand that if you are going to provide information to the court, it must be truthful, even if it could result in court-imposed sanctions.

Be sure to follow the policies and procedures of your business or employer. If in doubt, contact your hospital or clinic's legal department or your malpractice carrier for guidance. You can also contact your patient's attorney, with their permission, to discuss the best next steps. Ultimately, respect your patient's autonomy; if they believe a letter could negatively impact their case, they have the right to withhold consent, and you should honor that decision.

CATR *would like to acknowledge valuable feedback from Dr. Paul Bryant.*

CARLAT VERDICT

Drug courts represent a shift from traditional criminal courts by emphasizing recovery over incarceration for nonviolent drug offenses. Healthcare professionals play an important role by providing the court with treatment recommendations and updates on participant progress. When communicating with the court, be sure to remain transparent with your patient, advocate for their recovery, and, if in doubt, consult with their defense attorney.

Q&A With the Expert

Opioid Use Disorder in Correctional Facilities

Elizabeth Needham Waddell, PhD

Associate Professor, OHSU-PSU School of Public Health & Section of Addiction Medicine, Division of General Internal Medicine, Oregon Health & Science University, Portland, OR.

Dr. Waddell has no financial relationships with companies related to this material.

CATR: Why is it important for clinicians to understand how addiction is treated in the correctional system?

Dr. Waddell: Clinicians who treat patients with active substance use or mental health disorders should understand these patients' elevated risk of incarceration and associated disruptions in treatment. For example, up to a third of persons who use heroin cycle through prisons and jails every year (Rich JD et al, *N Engl J Med* 2011;364(22):2081–2083). A recent Pew study found that nearly 10% of adults with co-occurring substance use and mental health disorders are arrested annually, which is 12 times more than adults without these challenges and six times more than those with a mental illness alone (www.tinyurl.com/yu9yem26). Providers who treat substance use disorders (SUDs) are likely to have patients heading into or out of jails and prisons. Supporting patients during periods of transition is crucial. When possible, patients should be able to enter jail or prison with their prescriptions. Adequate release planning to connect patients to treatment after release is an important piece of helping them reintegrate into the community.

CATR: How big of a problem is addiction in correctional facilities?

Dr. Waddell: It's a massive problem, and opioid overdoses are a leading cause of mortality after release. In mid-2022, there were more than 630,000 people held in jails and over 1.2 million people incarcerated in US prisons, and additional research suggests that more than half of people in prison have an SUD (www.tinyurl.com/ncf2ad8h; www.tinyurl.com/5dr2ptvz). How many have an opioid use disorder (OUD) specifically? That's difficult to answer because we don't have great data. Based on findings from the Bureau of Justice Assistance's National Inmate Survey (2007, 2008–2009), 15% of males and 22% of females in state prisons regularly used "heroin/opiates" prior to incarceration. Among sentenced jail inmates, 17% of males and 25% of females used heroin or opiates (Bronson J et al. *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007–2009*. Bureau of Justice Statistics Special Report. NCJ 250546; 2017). Other research suggests that up to 20% of adults in custody in the US have an OUD (Joudrey PJ et al, *Addict Sci Clin Pract* 2019;14:17).

CATR: How often is treatment available for inmates?

Dr. Waddell: Treatment options don't meet the need, though it's difficult to know the full scope. A 2019 survey found only 64% of new jail admissions were screened for OUD (Maruschak LM et al. *Opioid Use Disorder Screening and Treatment in Local Jails, 2019*. Bureau of Justice Statistics. NCJ 305179; 2023). We do know that within facilities that have the capability, about 15% of folks screened are positive for OUD. So even though we don't have exact numbers, we know there are hundreds of thousands of adults in custody with OUD.

CATR: What can providers do for OUD patients prior to incarceration?

Dr. Waddell: Clinicians usually don't know when someone is going to be detained. In those cases, good OUD treatment before going to jail is critical.

CATR: Why is that?

Dr. Waddell: People coming into jail with a community prescription for buprenorphine, for example, will be more likely to get it continued compared to someone without a prescription. Encourage patients to advocate for themselves if they know they are facing incarceration by requesting that their prescription be sent to jail health services, or by requesting a paper copy of their prescription in advance. Sometimes the most effective means for care coordination is a phone call between providers. Of course, this is not the norm, but it is a practice to strive for. Having dedicated staff to coordinate care is essential.

CATR: How about correctional facilities that aren't set up to provide medications for opioid use disorder (MOUD)?

Dr. Waddell: Unfortunately, not all facilities prescribe MOUD. Anecdotally, I've heard about patients reluctant to start MOUD if they are likely to be incarcerated—because why start taking a medication if they're just going to be taken off it? They don't want to go through buprenorphine withdrawal, especially in a jail where they won't be given medication for withdrawal management. But, if they're not on MOUD, they'll just withdraw from whatever opioid they are using and are far less likely to get treatment in jail.

CATR: What about long-acting formulations?

Dr. Waddell: Long-acting injectable buprenorphine or naltrexone can work well. The long half-life ensures a gradual tapering of serum levels, and withdrawal symptoms are much less severe if the medication is discontinued. The injectables can be challenging to start for outpatients but are a good option for those worried about withdrawal (Lee JD et al, *Lancet* 2018;391(10118):309–318). Injectables are also expensive, but they should be considered when possible for people heading into the carceral system.

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Expert Interview – Opioid Use Disorder in Correctional Facilities

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CATR: And what about within facilities? When someone with OUD comes in, what are the options?

Dr. Waddell: First, it's important to distinguish between jails and prisons. Jails are local facilities, usually managed by a city or county, meant for holding people awaiting trial or serving sentences of under a year. People sometimes remain in jail for a long time, but that is not by design. Prisons are state or federal facilities that hold people serving longer sentences. Jails are usually more limited in the services they provide. In 2019, the Bureau of Justice Assistance found that only about half of jails offer withdrawal treatment. That might be buprenorphine, but not necessarily. When buprenorphine is offered as part of withdrawal treatment, it may be given for five days then tapered. Only 24% of jails continued MOUD, and 19% provided MOUD prior to release. And keep in mind that release from jail can happen without much notice, so getting a medication properly started can be hit or miss. Location matters too; urban jails are more likely to give MOUD than rural jails (Maruschak et al, 2023).

CATR: How do prisons differ?

Dr. Waddell: In a prison situation, stays are most often for a year or more in a single facility. There is more time for treatment, and more services are available. For example, some offer longer-term addiction treatment, individual counseling may be available, and there is more time for prerelease planning. In Oregon, long-acting injectable buprenorphine is offered to all adults who have a release date within 13 months. In a best-case scenario, adults in custody will work with a release counselor or peer navigator who can connect them to community care.

CATR: How can providers find out if facilities provide MOUD?

Dr. Waddell: That is an important question without an easy answer. It's kind of incredible, but there is no online database where you can find out what facilities offer what treatment. Sometimes state prison systems share a formulary across facilities, but not always, and local jails tend to have their own procedures. On top of that, it's a moving target depending on fluctuating funding, staffing, and local regulations. The most effective way to find out what is available is just to call the facilities around you.

"Educate patients about the higher risk of overdose upon release, particularly among those who have not been using while incarcerated. If they exit the carceral system and start using, they're at a higher risk for overdose due to a loss of tolerance and the presence of fentanyl in the drug supply."

Elizabeth Needham Waddell, PhD

CATR: We've talked about how to best care for our OUD patients before they are incarcerated. What happens when they are released?

Dr. Waddell: People leaving correctional facilities are incredibly vulnerable. They often have very few supports, no job, and hardly any money. After release, they have much higher levels of morbidity and mortality from chronic health conditions, mental health issues, and addiction, especially from OUD. Nationally, overdose is a leading cause of death among adults released from incarceration (Binswanger IA et al, *Ann Intern Med* 2013;159(9):592–600). Mortality risk is especially elevated in the two weeks after release, when individuals reenter living situations with exposure or access to substances for which they have little tolerance (O'Connor AW et al, *Drug Alcohol Depend* 2022;241:109655).

CATR: What can we do about this?

Dr. Waddell: One relatively easy lift is patient education about the higher risk of overdose upon release, particularly among those who have not been using while incarcerated. If they exit the carceral system and start using, they're at a higher risk for overdose.

CATR: You're referring to loss of tolerance?

Dr. Waddell: Yes, and the danger of the drug supply itself. Fentanyl is much more common in the opioid supply than just a few years ago. It's in methamphetamines and counterfeit pressed pills. Someone coming out of prison after a few years will be encountering a new, riskier, and more unpredictable drug supply.

CATR: What else?

Dr. Waddell: Many people coming out of facilities will be traumatized and fearful, not wanting to talk with anyone in a position of authority. But establishing trust is essential. Treatment may be seen as punishment, especially if they have experienced mandatory SUD treatment. Be open and honest. Learn about trauma-informed care, and make your office a safe space, not an interrogation room *(Editor's note: For more on trauma-informed care, see* CATR *Nov/Dec 2022)*. Familiarize yourself with local and state regulations about what information is reportable or not. Ideally, parole and probation supervisors will have knowledge of MOUD and counties will have clear policies that support MOUD treatment. Care coordinators and counselors who are able to connect directly with community connections (with the patient's permission) can be helpful. Most importantly, let patients know that their well-being is your top priority as a health care provider, and that you won't abandon them or "turn them in" if they return to use.

CATR: And what can we do in terms of the care itself?

Dr. Waddell: Ensure that if MOUD is not started before release, it's started as soon as possible. Every day after release without treatment increases the probability of a bad outcome. Providers should be flexible, especially right after release as people are getting their lives back together. Consider telehealth, especially in rural settings. Some prisons have care coordinators that set up community follow-up; collaborate closely with them. Provide or refer for medical treatment and screen for transmissible infections

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Drug Testing and the Legal System

Paul A. Bryant, MD, Assistant Professor of Psychiatry; Stephanie Eng, MD, Fellow in Forensic Psychiatry; Melissa Lavoie, MD, Fellow in Forensic Psychiatry. Yale University, New Haven, CT.

Drs. Bryant, Eng, and Lavoie have no financial relationships with companies related to this material.

Urine drug testing for patients with substance use disorders (SUDs) can be a fraught topic if those patients are involved in the legal system. Tests that would otherwise be routine can have disastrous consequences. Here, we'll review testing basics, describe how tests are used in legal settings, and advise you on how to order, interpret, and document results.

The basics of urine drug testing

There are two types of urine drug tests: a urine drug screen (UDS), which utilizes immunoassay technology, and a confirmatory test, which involves the use of gas chromatography–mass spectrometry (GC-MS).

Clinics throughout the world utilize the UDS; patients urinate into a cup and results are ready in a few minutes. These screens are quick and cheap but can be prone to false results. Amphetamine and opioid screens are notorious for false positive results due to antibody cross-reactivity, with one study finding a false positive rate of ~14% for amphetamines and ~34% for opioids (Johnson-Davis K et al, *J Anal Toxicol* 2016;40(2):97–107). For more information, see "Urine Drug Screens: What You Need to Know" in *CATR* May/June 2022.

Confirmatory testing is slower and more expensive but has a sensitivity and specificity approaching 100%, so it is usually reserved for UDS results that are being questioned. But even confirmatory tests cannot always be relied upon. For example, in 2021, the Department of Justice's investigation into the laboratory testing company Averhealth revealed that up to 30% of drug test results that they provided to Michigan's child welfare agency were false due to poor quality control and machine calibration issues (Hines A. Drug-Testing Company Used in Child Custody Cases Investigated for Fraud. *Vice*. January 27, 2023).

How drug testing is used in the legal system

Drug testing is routinely performed throughout the legal system with different considerations and potential consequences at each stage:

- *Arrest.* A positive drug test at arrest can result in higher bail or revocation of bail entirely.
- *Pretrial.* Drug testing may be a condition of pretrial release, with a positive result leading to reincarceration.
- *Sentencing.* A history of positive tests can lead to longer sentences.
- *Incarceration.* Inmates with a positive drug test may lose privileges or be subject to disciplinary action.
- *Community monitoring.* Drug testing is a common requirement during probation and parole. A positive test can result in stricter monitoring guidelines or even imprisonment.
- *Child custody cases.* Positive drug testing can lead to removal of the child from the home, limits on visitation, or loss of custody.

The UDS is the most common type of test used in the legal system, sometimes without confirmatory testing (Lang L. *Investigation of New York State Department of Corrections and Community Supervision*. State of New York Offices of the Inspector General. January 2022). Given the potential for false positives, there is widespread concern that people are being wrongfully arrested, convicted, or otherwise penalized (www.tinyurl.com/ycxear5x). One 2022 report found that over an eight-month period, 1,600 inmates were unjustly penalized with solitary confinement, denial of family visits, and delayed parole hearings based on false positive UDS results in the New York state prison system alone (Zraick K. N.Y. Prisons Punished 1,600 Based on Faulty Drug Tests, Report Finds. *New York Times*. January 4, 2022).

What can providers do?

Think before you order

Even if you work outside the courts, your records can be subpoenaed. Providers should order urine drug testing judiciously and only when clinically indicated. While a UDS can be an important tool, these screens can be prone to error, with potentially devastating consequences.

The optimal frequency for routine urine drug testing is usually left up to the provider. We recommend testing more frequently early in treatment and spacing tests out as treatment progresses. Patients who are stable and doing well probably do not need a UDS at every visit. As a general guideline, if your suspicion of drug use is so low that a positive result would surprise you, it may be worth reevaluating whether to order a UDS in the first place. See our interview

Continued on page 9

Common Causes of False Positives

Substance	Potential Cause of False Positive	
Alcohol (ethyl glucuronide)	Urinary tract infection	
Amphetamines	• Amantadine • Bupropion • Chlorpromazine • Desipramine • Dextroamphetamine • Labetalol • Levomethamphetamine • Methylphenidate	• Phentermine • Phenylephrine • Promethazine • Pseudoephedrine • Ranitidine • Selegiline • Thioridazine • Trazodone
Benzodiazepines	• Oxaprozin	• Sertraline
Cannabis	• Dronabinol • Efavirenz	• NSAIDs • Proton pump inhibitors
Cocaine	None	
Fentanyl	• Labetalol • Risperidone	• Trazodone • Ziprasidone
Opioids	• Dextromethorphan • Diphenhydramine • Doxylamine • Poppy seeds • Rifampin	• Quetiapine • Quinolone antibiotics ("floxacin") • Verapamil
Oxycodone	• Naltrexone	• Naloxone

Drug Testing and the Legal System

Continued from page 8

Example Documentation of Unexpected Positive UDS

"A urine drug screen was conducted as part of the clinic's routine monthly testing protocol. The test indicated the presence of fentanyl, which was surprising. The patient has been consistently stable on a prescribed regimen of buprenorphine for the past five years without any evidence of opioid or other illicit drug use, as verified by previous testing. He denies any recent opioid use, and his consistent medication adherence and stable recovery suggest that the result may not be accurate. Of note, the patient is prescribed trazodone, which is known to cause false positive results on fentanyl drug screens. The sample has been forwarded for confirmatory GC-MS testing to rule out the possibility of a false positive. Until we receive the confirmatory results, this initial positive finding for fentanyl should be interpreted with caution."

with Dr. Becker in *CATR* May/June 2022 for a more in-depth discussion of this topic.

Order confirmatory testing
Familiarize yourself with causes of UDS false positives. Many are outlined in the "Common Causes of False Positives" table on page 8. Whenever possible, order confirmatory testing for suspicious results, especially for the more error-prone tests like amphetamines, opioids, and fentanyl. Though not perfect, confirmatory testing is vastly more reliable than UDS. Moreover, GC-MS reports provide drug levels, allowing providers to trend results over time and demonstrate abstinence if levels consistently decline.

Document carefully
If you encounter a patient with an unexpectedly positive UDS, a detailed and well-reasoned note could go a long way in protecting them from negative legal repercussions. Clarify why the test was ordered, the reliability of the test, and why you question the positive finding. See "Example Documentation of Unexpected Positive UDS" box.

CARLAT VERDICT

Urine drug testing can be a double-edged sword in the treatment of SUDs, serving as a useful clinical tool but possibly carrying significant legal weight. A UDS is ubiquitous and quick but can give false results, while a confirmatory test is accurate but still not entirely foolproof, in addition to being expensive and slow. As a clinician, order drug testing judiciously, utilize confirmatory testing for accuracy, and carefully document unexpected results to safeguard patients from potential legal ramifications.

Expert Interview — Opioid Use Disorder in Correctional Facilities

Continued from page 7

Clinical Resources for Substance Use Treatment in Corrections

Resource	Description
American Society of Addiction Medicine (ASAM)	Policy and advocacy resources: www.tinyurl.com/5de5b8px
Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSUP)	Educational materials, newsletters, free webinars, podcasts, fact sheets, and resources from federal agencies: www.cossup.org/topics
Justice Community Opioid Innovation Network Training and Technical Assistance (JCOIN TTA)	Free training and support services to help justice and behavioral health agencies put research into practice to improve substance use disorder treatment delivery: www.jcoinctc.org/tta
National Commission on Correctional Health Care (NCCHC)	Information and support for delivery of medications for opioid use disorder in jails: www.ncchc.org/jail-based-MAT
Substance Use and Mental Health Services Administration (SAMHSA)	• Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: www.tinyurl.com/yjhuf29f • Best Practices for Successful Reentry From Correctional Settings: www.tinyurl.com/32b7tve2

like HIV and viral hepatitis. Remember, not everyone is going to be ready for SUD treatment, but clinicians still need to engage with these patients.

CATR: This is where harm reduction interventions can be useful.

Dr. Waddell: Exactly. Harm reduction is a priority for these patients (www.tinyurl.com/48rhnh6u; www.tinyurl.com/yvcp68xe). Basic harm reduction approaches, including education about safer use and distribution of naloxone and sterile syringes, are so important. Start with conversations about safer use. Be sure your patients have naloxone available and know how to use it. Remind them not to use alone when possible.

CATR: Is there anything else that we can do to help these patients?

Dr. Waddell: As providers, the instinct is to start medication right away. But we should remember that medication, while important, may not be patients' top priority. Prison sentences, especially long ones, will have completely upended their lives. They will be interested in housing, employment, and reconnecting with loved ones. Talk to patients about how OUD treatment might help to achieve these goals. Practices can provide referrals to social services like financial assistance, food stamps, and housing. Involve peer supports when possible. If you can help your patient with what matters to them, they will be more likely to engage and more likely to succeed. (*Editor's note: See table for additional resources.*)

CATR: Thank you for your time, Dr. Waddell.

❖ ❖ ❖

Research Updates

OPIOID USE DISORDER

Buprenorphine Versus Methadone for Opioid Use Disorder in Pregnancy

Richard Moldawsky, MD. Dr. Moldawsky has no financial relationships with companies related to this material.

REVIEW OF: Suarez EA et al, *N Engl J Med* 2022;387(22):2033–2044
STUDY TYPE: Cohort review

Ever since the seminal MOTHER trial, buprenorphine and methadone have been the gold-standard treatments of opioid use disorder (OUD) during pregnancy. But the two agents are not necessarily equivalent, with buprenorphine being associated with milder neonatal withdrawal syndrome (NOWS) and reduced hospital stays (Jones HE et al, *N Engl J Med* 2010;363(24):2320–2331). Despite its significance, the MOTHER trial was fairly limited in scope, with just 175 participants. To validate the findings in a much larger group of patients, researchers utilized a Medicaid database of over 2.5 million pregnancies, nearly 16,000 of which were exposed to buprenorphine or methadone.

The researchers found that buprenorphine-exposed newborns had significantly better outcomes than those exposed to methadone, with a lower risk of NOWS (52.0% vs 69.2%, relative risk [RR]=0.73, 95% confidence interval [CI]=0.73–0.75), preterm birth (14.4% vs 24.9%, RR=0.58, 95% CI=0.53–0.62), small size for gestational age (12.1% vs 15.3%, RR=0.72, 95% CI=0.66–0.80), and low birth weight (8.3% vs 14.9%, RR=0.56, 95% CI=0.50–0.63). On the other hand, parental outcomes did not differ in rates of cesarean section delivery, and severe pregnancy complications were similar between the two groups.

Limitations of this study derive mostly from its design as a retrospective cohort study; we don't know how patient outcomes might compare to those of patients with untreated OUD. We also lack data that might influence the results, such as medication dose, parental lifestyle, and behavioral factors. All the information came from a Medicaid database, which has variable coverage across states, potentially influencing which patients were included.

CARLAT TAKE
This large retrospective cohort study makes a compelling argument for treating OUD with buprenorphine over methadone during pregnancy, at least in terms of neonatal outcomes. Parental adverse outcomes were comparable. Although there was no placebo group, treatment with either medication is certainly better than no treatment. Therefore, treat all pregnant OUD patients with opioid agonist treatment, and all else being equal, lean toward buprenorphine over methadone.

CANNABIS

Does Cannabis Legalization Increase the Risk of Driving-Related Injury?

Garrett Rossi, MD. Dr. Rossi has no financial relationships with companies related to this material.

REVIEW OF: Brubacher JR et al, *N Engl J Med* 2022;386(2):148–156
STUDY TYPE: Prospective study

As recreational cannabis use has grown in popularity and accessibility, so have concerns about the risks of cannabis-impaired driving. While we know that cannabis can impair driving performance in a controlled setting (see *CATR* Jan/Feb/Mar 2023), what about in the real world?

Canada's nationwide legalization of recreational cannabis in 2018 provided researchers with an opportunity to answer this question. They identified 4,339 drivers treated for moderate injuries from motor vehicle collisions who submitted blood samples as part of their care between 2013 and 2020. Authors divided the drivers into a pre-legalization group (January 2013–September 2018) and a post-legalization group (November 2018–March 2020) and compared THC and alcohol serum levels between them.

The results were eye-opening. The percentage of drivers with THC in their blood nearly doubled after legalization (from 9.2% to 17.9%). The percentage of drivers with a THC level at or above the Canadian legal limit of 2 ng/mL increased from 3.8% to 8.6%, while the percentage of drivers testing at ≥5 ng/mL increased from 1.1% to 3.5%. There was no concomitant increase in the prevalence of drivers testing positive for alcohol. Interestingly, the increase was most pronounced among older drivers (over the age of 50) and male drivers.

There were several limitations to this study. It only included moderately injured drivers, so those with minor injuries or fatal accidents were not accounted for. Additionally, there was variability in the time between the collision and the serum sample, which could impact the accuracy of the THC levels. And although a causative link between cannabis prevalence and injury is plausible, the data in this study remain purely associative.

CARLAT TAKE
This prospective study found that the proportion of moderately injured drivers testing positive for THC increased after the passage of a recreational cannabis law. Patients are aware of the dangers while driving under the influence of alcohol, but this study suggests that you should advise your patients to avoid driving after using cannabis as well.

ALCOHOL USE DISORDER

Daily Alcohol Intake and Risk for All-Cause Mortality

Eli Neustadter, MD, MSc. Dr. Neustadter has no financial relationships with companies related to this material.

REVIEW OF: Zhao J et al, *JAMA Network Open* 2023;6(3):e236185
STUDY TYPE: Systematic review and meta-analysis

It was once thought that low to moderate drinking was protective; however, these findings have recently been called into question. The original studies compared drinkers with abstainers and reported that continuing to drink led to health benefits.

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CE/CME Post-Test

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These questions are intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Learning objectives are listed on page 1.

1. What is one advantage of drug courts compared to the traditional court system (LO #1)?
   [ ] a. Shorter time commitment
   [ ] b. Focus on substance use treatment
   [ ] c. Greater racial equity
   [ ] d. Judges with specialized medical training

2. According to Dr. Johnson, which of the following is a leading cause of maternal mortality in the first year postpartum (LO #2)?
   [ ] a. Opioid overdose [ ] b. Stimulant overdose [ ] c. Alcohol use [ ] d. Suicide

3. What drugs have the highest rate of false positives in a urine drug screen (UDS) (LO #3)?
   [ ] a. Alcohol and nicotine
   [ ] b. Barbiturates and benzodiazepines
   [ ] c. Cannabis and cocaine
   [ ] d. Opioids and amphetamines

4. According to a 2022 prospective study, how did THC blood levels in drivers change after cannabis legalization in Canada (LO #4)?
   [ ] a. The percentage of drivers with detectable THC levels decreased slightly
   [ ] b. THC levels showed a moderate increase primarily in men under 30
   [ ] c. The percentage of drivers with detectable THC levels nearly doubled
   [ ] d. THC levels and those testing positive for alcohol increased at the same rate

5. What is a key requirement for referral to drug court (LO #1)?
   [ ] a. Nonviolent charge
   [ ] b. History of incarceration
   [ ] c. First offense
   [ ] d. Long history of substance use disorder

6. According to Dr. Waddell, what percentage of female jail inmates use heroin or opioids (LO #2)?
   [ ] a. 10% [ ] b. 34% [ ] c. 17% [ ] d. 25%

7. True or false: Confirmatory testing via gas chromatography–mass spectrometry should be used to verify the accuracy of a UDS when false results are suspected (LO #3).
   [ ] a. True [ ] b. False

8. What did a 2022 study find regarding treatment of opioid use disorder during pregnancy (LO #4)?
   [ ] a. Buprenorphine-exposed and methadone-exposed newborns had comparable health outcomes, but the latter group had better parental outcomes
   [ ] b. The buprenorphine group had significantly better neonatal outcomes compared to the methadone group
   [ ] c. Rates of severe pregnancy complications were comparable to the placebo group
   [ ] d. Parental adverse outcomes were less severe in the methadone group

Research Updates

Continued from page 10

It turns out that the "abstainer" comparison groups were often composed of people who stopped drinking due to medical illness rather than as a lifestyle choice. The abstainers were therefore sicker than would otherwise be expected, skewing the results in favor of participants who were drinking.

In the current systematic review and meta-analysis, researchers collated results from 107 cohort studies (~4.8 million participants) to look at the relationship between alcohol use and risk of death. Participants were broken up into four groups: abstainers, moderate drinkers (two to three standard drinks/day), high-volume drinkers (three to four standard drinks/day), and highest-volume drinkers (five or more standard drinks/day). Contrary to previous reports, no amount of alcohol consumption was associated with any improvements in mortality. High-volume drinkers had a nearly 20% increased risk of death and highest-volume drinkers had a 35% increased risk of death during study follow-up periods (ranging from approximately four to 40 years) compared to lifetime abstainers.

The authors also identified important sex differences. Moderate drinking led to increased death rates for women, but not for men, whose death rates increased only among high-volume and highest-volume drinkers. Females had a greater chance of dying than males for all levels of alcohol use.

Additionally, researchers noted that the amount of alcohol consumed in most of the included studies was self-reported. Given that self-reported alcohol consumption is consistently underreported, mortality risks for alcohol use were likely underestimated.

CARLAT TAKE

This study finds that no amount of drinking provides protection against mortality. On average, approximately two standard drinks/day increases mortality risk for females, while males see increased risk at around three or more standard drinks/day.

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Note From the Editor-in-Chief

Preliminary federal data show that overdose deaths in the United States declined for the first time since 2018, and for only the second time in two decades, from 111,029 in 2022 to an estimated 107,543 in 2023 (www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm). This encouraging finding is attributed to reduced deaths from synthetic opioids like fentanyl and its derivates. Despite the good news, mortality numbers are still high, some populations have seen increased deaths (Black and American Indian, non-Hispanic in particular), and deaths from stimulants such as cocaine and methamphetamine have increased. Continue to offer evidence-based addiction treatments to all your patients with substance use disorders, and whenever possible, utilize harm reduction measures like fentanyl testing and naloxone distribution.

—Noah Capurso, MD, MHS
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